Stakeholder Advisory Group Meeting
Wednesday, October 26th
9:00 am – 12 noon
Williston Fire Department

Present: Jeanne Hutchins, FAHC; Julie Tessler, VT Council of DMHS; Marlys Waller, VT Council of DMHS; Carrie Hathaway, DVHA; Brendan Hogan, Bailit Health; Theo Kennedy; Bailit Health; Lisa Carpenter, DVHA; Michael Benvenuto, VT Legal Aid; Rachel Parker, Starr Farm Nursing Center; Laura Pelosi, VHCA; Meagan Buckley, Berlin Health & Rehab.; Sam Abel-Palmer, VT Legal Aid; Janet Dermody, VCIL; Lila Richardson, Ombudsman; Kathleen Denette, Rate Setting; Ed Upson, Clara Martin Center; Julie Trottier, Cathedral Square; Larry Goetschius, Addison County Home Health; Sarah Russell, Burlington Housing Authority; Leslie Wisdom, Rate Setting; Lorraine Siciliano, DVHA; Sam Liss, SILC; Frank Reed, DMH; Michael Hartman, ACS; Tara Casey, FAHC; Dennis Houle, LCC; Ed Paquin, Disabilities Rights; Karen Schultz, DD; Dion LaShay, Consumer; Council; Susan Besio, PHPG, Scott Wittman, PHPG; Debra-Lisi-Baker, Consultant; Patrick Flood, Dale Brooks, Bard Hill, and Julie Wasserman, Duals Project.

Susan Besio led the group through four beneficiary scenarios. See Beneficiary Handout. Questions and comments follow.

<u>Lana</u>

- How will the system including physician and care coordinator know in real time that Lana went to the ER? Possible methods include claims data or billing data; Community Health Teams; electronic health records, and/or a hospital obligation to report patient admissions and ER visits.
- How does an individual get "flagged" if there is a change in condition that would warrant offering the individual access to a care coordinator?

<u>Peter</u>

- What is the threshold of need for getting access to a Capitated Integrated Provider (CIP)? Are there people who cannot access one?
- What is the Individual Budget? Is it a literal budget for each person? Is it a set of parameters a provider can use to create a service package for a person? Is it a per person per month payment that drives an aggregate budget for a group of people? In Children's Services, programs are moving away from individual budgets.
- Will there be more than one Capitated Integrated Provider in a given region? The plan is to work with existing providers as integrated providers. (Note possible implications for state law and regulation regarding which organizations can provide specific types of services.)
- Would we or would we not want to give the existing providers the opportunity to serve others by expanding services? In a person-centered model that includes a person's choice of services and providers, providers would have the opportunity to expand and integrate additional services.
- How do we leverage PCPs to accept people with challenging behaviors or histories? Utilize Blueprint strategies (incentive payments, access to Community Health Teams).

Blueprint should have a statewide presence with most all physician practices by 2013. Other approaches: VCCI, Dual Project care coordinators, possible contractual arrangements between PCPs and CIPs. These should improve the coordination of services. Also noted were ACA increases in Medicaid reimbursement rates. Even though some individuals will have a difficult time finding PCPs, the health home and Community Health "Team" approach often help MDs accept people with challenging behaviors/histories. Consider higher reimbursement under Blueprint for people with challenging behaviors/histories?

- What happens to individuals who go on and off of Medicare/Medicaid? Medicare participation is more stable than Medicaid participation. How will enrollment and disenrollment work?
- Does the CIP provide services or does the Blueprint Community Health Team? At what point does the responsibility shift from the Community Health Team to the CIP? Need clear parameters to delineate this, including how different providers will be paid.
- How do the CIP and the Community Health Team integrate with existing care coordinators from CFC, CRT, DS, TBI, etc?
- Do you ever "come off" a CIP? Yes, if your needs change. How will this be managed?
- What happens if Peter doesn't follow-up with the services he was offered? In the new system, the CIP would be responsible for follow-up. Every CIP should have a multidisciplinary team to address their clients' needs. When people say "no", it is oftentimes because the services offered are not the services needed. The new person centered system is intended to allow for creativity in meeting clients' needs. If a person wants nutrition counseling with his PCP rather than the Community Health Team, we need to accommodate that.
- Are services mandatory? No, they are not.
- Who is eligible to become a CIP? Do you need to apply to become one? Are there guidelines? How will the Duals Demonstration Project determine who can be a CIP? Professional development will be needed. These will be determined after we decide how a CIP works.
- Where is the entry point for a person whose primary services are not connected to a CIP?
- We need to find a way to improve coordination between private mental health therapists and the designated agency mental health service providers.
- What about people not associated with a Blueprint health home or those who do not have a PCP? How will we address these gaps?
- How does an individual access a CIP? The enrollment and disenrollment process should not be burdensome, especially for those moving into and out of the system.

<u>Charlie</u> – this scenario assumes Charlie is associated with a CIP

- Had there been adequate availability of Personal Care Attendants (PCAs), Charlie would have avoided this hospitalization. A consistent and reliable supply of PCAs needs to be part of the infrastructure. How will this occur? Who will be responsible for this?
- Future topic to discuss: Which services should be tied to infrastructure and which to the individual plan (e.g. should care coordination be considered a 'core capacity' and be separate from the individual budget)?
- Duals Demonstration project will be similar to PACE and could be considered PACE without walls. However in PACE, the PACE provider accepts responsibility and financial risk for all Medicare and Medicaid services.

- Could individuals self-manage without a CIP? Under the design discussed to date, all CIPs need to support self-management. A person could utilize either a CIP, an ARIS arrangement (similar to current CFC), or a peer-organization.

Ben – this scenario assumes Ben's DS Designated Agency is a CIP

- The current case manager in the Developmental Services (DS) system could be the care coordinator. It is important to preserve existing and established relationships. Care needs can be met by the current DS service package. The State Guardian is involved as well; we need to consider the relative roles of the person, the guardian, family, and the care coordinator.
- If there are multiple CIPs in a given region, will there be enough volume for the capitated payment system to work for all of them? Any of them?
- The CIP approach may cause individual providers operating on thin margins to set up their own system by hiring internally to save on costs. This would create duplication of services across providers, with increased costs to the system. How would savings then come from "integrated" care?
- CIPs need to be able to adjust care coordination capacity based on changing demand.
- The CIP does not bear all the financial risk.
- How will we measure savings? How will we share savings with the person, the CIP, other providers, the State, and CMS?
- Are all dually eligible individuals eligible to receive CIP services? Yes. If a CIP is available to all, how will we support the costs of additional care coordination? How will we address savings at both the individual level and the aggregate level?
- Can there be a population-based seamless way for a person to be referred for care coordination services who does not need a CIP (e.g. Blueprint Community Health Teams)?
- Will all dually eligible individuals have access to service coordination even if they do not need the services of a CIP? In other words, can care coordination be provided without full CIP service integration?

Future Meeting Schedule:

* Cancel Stakeholder Advisory meeting on October 31, 2011
* Meet November 15, 2011 on Financing issues; and November 28, 2011
* Working on setting up a video conference with Commonwealth Alliance. (Tentative date of November 1, 2011 has been cancelled).